State of New Jersey
Department of Labor and Workforce Development

# **ORDER FOR**

CASE NO'S.:		
VICINAGE:		

	ISION OF WORKERS' COMPENSATION	_		SABILITY njury Fund	VICINAGE:	
WC-	-376(03-29-06)				VICHVIOL.	
	SOCIAL SECURITY NUMBER:		] <sub>#</sub>	SSN FEDER	RAL EMPLOYER NUMBER NJ REG NUMBER	
ER	NAME:	DOB:	IONE	NAME:		
PETITIONER	GENDER: MALE F	EMALE	ATTORNEY FOR PETITIONER	ADDRESS:		
PET	ADDRESS (Including County):		FOR			
			RNEY	TELEPHONE NUMBER (AREA CODE):		
	VS		TTOI	APPEARING:		
ENT	NAME:		7	L		
RESPONDENT	ADDRESS (Including County):		E ~	NAME	SELF-INSURED TPA	
			INSURANCE CARRIER	CLAIM NUMBER:		
	NAME:			DATE OF ACCIDENT OR		
FOR ENT	ADDRESS:			OCCUPATIONAL EXPOSURE: DESCRIBE (Briefly):		
NEY ONDI						
ATTORNEY FOR RESPONDENT	TELEPHONE NUMBER (AREA CODE):					
<b>A</b>	APPEARING:					
	APPEARING FOR SECOND INJURY FUND:			FUND PETITION FILE DATE:		
	Unon the proofs presented	and the stinular	_ tions	made I find and d	etermine the following facts:	
		-		mauc, i iiiu anu u	etermine the following facts.	
LA	ST COMPENSABLE ACCIDENT	OR EXPOSUR	E			
WA	GES: RATE:			Date of last payment of	f Permanent Compensation by Respondent:	
	accordance with the provisions of the	New Jersey Worl	kers'	Compensation Law	(N.J.S.A. 34:15-1 et seq.),	

Permanent Disability payable by Respondent (Describe Percentages, Nature and extent of Disability, and Members involved):

Petitioner is totally and permanently disabled as of

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# ORDER FOR TOTAL DISABILITY w/Second Injury Fund - Page 2

CASE NO'S.:		
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AWARD WITHOUT SO	CIAL SECURITY OFFSETS				
TEMPORARY:	Weeks at \$	= \$	less \$	paid = Balance due \$	
PERMANENT:	Weeks at \$	= \$	less \$	paid = Balance due \$	
			Volu	ntary Tender Reopener Credit	
PAYMENTS DUE FROM	I RESPONDENT WITH SOC	CIAL SECURITY	Y OFFSETS		
Payments before offset beg	ins weeks	at \$	less \$	Paid = \$	+
Payments with auxiliaries			less \$		+
After auxiliaries				Paid = \$	
After offset completed		at \$		Paid = \$	
TOTAL PAYMENTS				\$	
b. c. d.	dingly, it is determined that  week permanent disability co 450 weeks has exp Payable base weekly ra  Awarded base weekly ra  Payment to begin upon any event, not sooner the Commencement date for	the petitioner recess, being the difference of the period of the difference of the period of the expiration of the expiration of the expiration of the for Fund benefits which is the expiration that the date of the period of the expiration of the	nd is clearly within the ceive benefits from the ference between 450 with without the ference between 450 with the ference between 450 with the ference between 450 week and is	petitioner's previous disabilities provisions of the above cited be Second Injury Fund as followeeks and the	statute.  vs: weeks of  ase explain below.  ion award, but, in ary Fund.
Petitioner's 80% ACE is	s and petition	ner's initial enti	tlement was \$	lement wasincluding \$	for auxiliary
petitioner's last auxiliary		ol or turns 18 ye	ars of age, whichever	t resulting in a rate of \$is later. Thereafter, until the	
[	Name	of Auxiliary		Date of Birth	

### ORDER FOR TOTAL DISABILITY w/Second Injury Fund - Page 3

CASE NO'S.:	
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Hearing Date:

The first weeks of perfee and costs.	ermanent disability are to be paid at	the full rate of \$	reflecting Petitioner's share of counsel		
☐ An Application for Social Security Disability Benefits and / or Government Ordinary Disability Pension ☐ is pending ☐ is on appeal ☐ has not been filed. Should Petitioner be awarded Social Security Disability Benefits and / or Government Ordinary Disability Pension, Petitioner shall immediately notify the Respondent and the Second Injury Fund of this award. The Petitioner shall reimburse the Respondent and the Second Injury Fund for any workers' compensation benefits paid to Petitioner in excess of the offset rate during the period of time Petitioner has received Social Security Disability benefits or Government Ordinary Disability Pension.					
In the event there is a change in the benefits, Petitioner shall immediate		y beneficiaries while Pe	etitioner is receiving Workers' Compensation		
	ny emergency arise, necessitating i		and medical supplies as the condition of the ntion for the Petitioner, notice and request to		
Respondent authorizes		as treating physician.			
The date of Petitioner's Permanen	nt Total disability is				
On, which is the expirate 12(b) as amended.	ration of the 450 week period, bene	efits to continue in acco	ordance with the provision of N.J.S.A. 34:15-		
	, petitioner will be referred to the 450 weeks from the date of Total Pe		al Rehabilitation Services for evaluation and		
PETITIONER DATA					
Date of Last Employment:	Occupation:		Gross Weekly Wages:		
PRE-EXISTING COMPENS	SABLE DISABILITIES				
Date of Injury:	Claim Petition Number:				
Employer Name:					
Permanent Disability Award:					
Description of Injury and Disability:					
Hearing Date:					
Date of Injury:	Claim Petition Number:				
Employer Name:					
Permanent Disability Award:					
Description of Injury and Disability:					

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CASE NO'S.: VICINAGE:

Date of Injury:	Claim Petition Number:		
Employer Name:			
Permanent Disability Award:			
Description of Injury and Disability:			
Hearing Date:			
Date of Injury:	Claim Petition Number:		
Employer Name:			
Permanent Disability Award:			
Description of Injury and Disability:			
Hearing Date:			
Date of Injury:	Claim Petition Number:		
Employer Name:	Employer Name:		
Permanent Disability Award:			
Description of Injury and Disability:			
Hearing Date:			
Date of Injury:	Claim Petition Number:		
Employer Name:			
Permanent Disability Award:			
Description of Injury and Disability:			
Hearing Date:			

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CASE NO'S.:		
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PRE-EXISTING NON-COMPENSABLE DISABILITIES

TRE-EASTING NON-COMI ENSABLE DISABILITIES	
Date of Onset:	Origin (if known):  Congenital Accident / Injury
Description:	
Date of Onset:	Origin (if known):  Congenital Accident / Injury
Description:	
Date of Onset:	Origin (if known):
Description:	Congenital Accident / Injury
Date of Onset:	Origin (if known):
Description:	Congenital Accident / Injury
Date of Onset:	Origin (if known):
Description:	Congenital Accident / Injury
Date of Onset:	Origin (if known):
Description:	Congenital Accident / Injury
Date of Onset:	Origin (if known):
Description:	Congenital Accident / Injury

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CASE NO'S.:		
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#### PETITIONER DATA

Education (highest level completed):	
Special Occupational Skills:	
Rehabilitation Potential:	
Third Party Actions:	
If third newty liability action is monding	
If third party liability action is pending, provide the name and address of the attorney	
representing this petitioner if different than the	
workers' compensation attorney, the defense	
attorney(s), the case name and docket number.	
(Despendent and Second Ini	uny Fund reconstruction rights under N. I.S. A. 24:15-40)
(Respondent and Second Inj	ury Fund reserve their rights under N.J.S.A. 34:15-40)

REMARKS:

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VICINAGE:

TAX IDENTIFICATION NUMBER

TOTAL AMT. ALLOWED PAYABLE BY PRESPONDENT

MEDICAL FEE ALLOWED (expert and/or testimonial)

ATTORNEY(S) FEE

STENOGRAPHIC SERVICE

MISCELLANEOUS FEES

			J		J	
STENOGRAPHIC SERVICE						
MISCELLANEOUS FEES						
☐ ORDER FOR CHILD SUPPORT ☐ ADDENDU					DDENDUM ATTACI	<del>I</del> ED
JUDGE OF COMPENSATION	DATE	_				
WE HEREBY CONSENT TO THE ENTRY ANI ORDER AND ACKNOWLEDGE RECEIPT OF O						
PETITIONER'S ATTORNEY		RESPONDENT'S A	RESPONDENT'S ATTORNEY			
PETITIONER (where applicable)	DEPUTY ATTORN	EY GENERAL				